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IN THE

Supreme Court of the United States

OCTOBER TERM, 1942

No. 878.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, a corporation, *Petitioner*,

vs.

JANE SAXE.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA, AND BRIEF IN SUPPORT THEREOF.

PETITION FOR WRIT OF CERTIORARI.

BENJAMIN S. MINOR,
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PETITION FOR WRIT OF CERTIORARI.

To the Honorable the Chief Justice and Associate Justices of the Supreme Court of the United States:

The petitioner, The Prudential Insurance Company of America, respectfully shows unto this Honorable Court:

SUMMARY STATEMENT OF MATTER INVOLVED.

This proceeding began October 4, 1938, by the filing of a suit by Petitioner in the District Court of the United States for the District of Columbia to cancel a policy of insurance, issued December 17, 1936 in the sum of $10,000.00 on the life of Alexander T. Saxe, obtained by the fraud of the insured in concealing that he had previously spent two weeks in a hospital and had been attended by physicians within three years preceding his application, and that he had been treated for a duodenal ulcer, none of which facts were disclosed in his application for the policy (R. 1).

On the next day, October 5, 1938, the original beneficiary, Jane Saxe, wife of the insured, instituted a suit against Petitioner in the same court to recover the proceeds of the policy (R. 13) and, subsequently, Gertrude T. Saxe, mother of the insured, was permitted to intervene in that case as a party plaintiff claiming the entire proceeds as beneficiary under a later designation (R. 24).

The District Court held that these claims to the proceeds of the policy were not compulsory counterclaims in the original proceeding brought by Petitioner and that they could be maintained as a separate action despite the provisions of Rule 13 of the Federal Rules of Civil Procedure. Over the objection of Petitioner, the two suits were tried together to a jury and the claimants to the policy proceeds were allowed to open and close (R. 25, 35).

The application, which was attached to and delivered with the policy as a part thereof, was received in evidence with the policy and showed that the insured represented that he had never been in a hospital, santarium or other institution for observation, diagnosis, rest or treatment, that he had not consulted or been attended by a physician during the preceeding three years, and that he had never had a disease of the kidneys, dizziness or gastric or duodenal ulcers (R. 153, questions 6D, 9A, 10A, part 1).

The proofs of death, which were received in evidence, showed that the insured died from a disease of the kidneys from which he had suffered at least ten years (R. 185, question 6).

At the trial Petitioner produced the testimony of Dr. Jacob Fine and the records of Beth Israel Hospital, in Boston, which established that the insured had been taken sick on a train in January, 1934, (R. 45, 159) had consulted Dr. Fine who, suspecting a bleeding duodenal ulcer, placed him in the hospital on January 16, 1934 (R. 47); that he underwent numerous examinations and tests and was attended by three other doctors while there (R. 47, 155-183), and when he was discharged on January 30, 1934, there was a definite diagnosis of duodenal ulcer (R. 48, 155). Petitioner also offered testimony from its Assistant Medical Director to show that the answers to questions propounded in the application were material to the acceptance of the risk but the trial court refused to receive such testimony on the ground that materiality was a question of law (R. 53). The trial court did receive evidence as to the general practice of insurance companies that in the event a hospital record had been disclosed which showed a diagnosis, or a suspected diagnosis, of duodenal ulcer within three to five years the applicant would have been rejected without further inquiry (R. 69).

Both claimants to the fund admitted that Saxe had spent two weeks in Beth Israel Hospital and had been treated by Dr. Fine (R. 22, 23) but contended that the concealment of that fact was immaterial because he did not have the duodenal ulcer shown by the hospital record and that this concealment was later waived by Petitioner (R. 24).

To support their first contention the claimants produced a Dr. Pope who examined the records of Beth Israel Hospital and then testified that, in his opinion, the information contained in such records did not jusitfy a final diagnosis of duodenal ulcer, although the staff members were correct in suspecting it on admission. While this testimony

is not in the printed record it is found in the opinion of the Court of Appeals, having been taken from the transcript filed with it (R. 194). The only other testimony respecting the physical condition of the insured was received from lay persons giving their opinion as to the supposed good health of the insured during this time (R. 74-78).

The contention with respect to the alleged waiver was based upon the testimony of Jane Saxe that a month before her husband died he told her that he had a previous hospital record which he had not disclosed to the insurance company and which his mother was then threatening to disclose, that on an occasion while he was building a house for Dr. Fine he had too much to drink and went to the hospital (R. 101, 126, 127) and that Dr. Fine said he would fix up something in the hospital records so as to keep his record at Columbia University straight (R. 104, 126, 127), that she told this to Brine, who was in charge of Petitioner's Washington Office (R. 104, 126, 127), who, by subsequently accepting premiums, waived any right of Petitioner to claim the policy was void because of the concealment of the stay in Beth Israel Hospital. Brine denied that he was given any information about Beth Israel Hospital (R. 115), and Petitioner contended that even if he had been given this information it was not sufficient to support a waiver because there was not a full disclosure, and because Brine had no authority under the provisions of the application (R. 153) and of the policy (R. 152) to bind Petitioner by receiving any representation or information.

This testimony with respect to the supposed cause for the stay in Beth Israel Hospital was admitted by the trial court for the sole purpose of showing the information given to Brine as a basis for the alleged waiver, but was expressly held by the trial court not to be binding on Petitioner (R. 82, 83, 85, 99, 101, 103, 109, 122, 127, 128). However, the Court of Appeals has seized upon this testimony, admitted for a limited purpose, and holds that it was

legally sufficient evidence to establish that the hospital record was fictitious (see Brief, pp. 14-17).

After a trial lasting six days, five of which were consumed by the dispute betwen the claimants to the policy proceeds, the trial court denied a motion to direct a verdict for Petitioner (R. 146, 147) and submitted the case to the jury, and a verdict for $10,000.00 in favor of Jane Saxe alone was returned in the suit which he had instituted against Petitioner (R. 143). No judgment or decree has ever been entered in the original suit filed by Petitioner, the trial court being of opinion that it was unnecessary in view of the verdict in the other case (R. 149).

The appeal was argued before three Justices of the United States Court of Appeals for the District of Columbia on November 10, 1941, (R. 187) and on January 25, 1943, the judgment below was affirmed with one Justice dissenting (R. 188).

The majority opinion (R. 188) holds:

(a) There was an issue between the parties as to whether the Beth Israel Hospital record was genuine or fictitious because of the evidence that insured was in the hospital only because of a "social lapse", that this issue affected nearly every other issue in the case, and had been decided against Petitioner on legally sufficient evidence;

(b) There was no evidence that the concealment of the hospital record was intentional, as required by Section 35-414 of the District of Columbia Code (post), and, as all the statute required was bona fide answers, the falsity of the statements in the application was for the jury to decide;

(c) To avoid the policy under the statute, post, it was necessary for the insurer to establish that the insured had the disease for which he was hospitalized and that it was the cause of death or existed when death occurred;

(d) The statement made by Jane Saxe to Brine a month before the insured died, that insured had not disclosed his stay in Beth Israel Hospital and that it was only caused by a "social lapse", was a sufficient disclosure of whatever would have been shown by the hospital records, and as a matter of law, constituted a sufficient basis for a waiver, notwithstanding the policy provision limiting the authority of agents in this respect;

(e) The claims to the proceeds of the policy were not compulsory counterclaims in the prior proceeding instituted by Petitioner for the cancellation of the policy, because that would compel a waiver of trial by jury.

The dissenting opinion (R. 210) holds that Petitioner's motion for a directed verdict should have been granted because the misstatements in the application were such that all reasonable jurymen must have found that they materially affected the acceptance of the risk, and there was not a sufficient disclosure of facts concerning the Beth Israel Hospital experience, and the medical history shown thereby, to support a waiver as a matter of law.

The two Justices who joined in the majority opinion on February 15, 1943, denied a petition for a rehearing of the case before the entire Court of six Justices (R. 212), apparently without any consideration by the remaining four Justices.

JURISDICTIONAL STATEMENT.

The statutory provision believed to sustain jurisdiction in Section 240(a) of the Judicial Code, as amended by the Act of February 13, 1925, c. 229, par. 1, 43 Stat. 938.

The date of the judgment of the United States Court of Appeals for the District of Columbia sought to be reviewed is January 25, 1943.

STATUTE INVOLVED.

The proceedings involve, among other things, the construction of the Act of Congress of June 19, 1934, 48 Stat. 1133, c. 672, par. 15, ch. II (District of Columbia Code (1940) sec. 35-414) as follows:

> "The falsity of a statement in the application for any policy of insurance shall not bar the right to recovery thereunder unless such false statement was made with intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the company."

QUESTIONS PRESENTED.

1. Can an appellate court lawfully take hearsay testimony which the trial court admitted for a limited purpose and upon only one issue, and, in order to sustain the verdict of a jury, use it for another and different purpose which the court says "affects nearly every issue in the case", when the opponent had no opportunity to meet such testimony on such an issue and the jury itself, under the rulings and instructions of the trial court, could not have used the hearsay testimony as a basis for its verdict.

2. Does the statute, *supra,* require proof from an insurer of an intention to deceive, and from an insured only bona fide answers to questions in policy applications concerning sojourns in hospitals and consultation with or attendance by physicians, where it is established that the answers to such questions are contrary to fact and relate to matters materially affecting the acceptance of the risk.

3. Does the statute, *supra,* require proof that the cause of the concealed hospitalization was the cause of death, or existed when death occurred, in order to avoid liability because of the falsity of a statement in an application concerning sojourns in hospitals and consultation with or attendance by physicians.

4. Does the representation to an insurer that the insured had been in a hospital because of a "social lapse" resulting from drink, and was not ill, constitute in law a sufficient basis for a waiver by the insurer of the fact that the record of such hospital actually showed admission for a suspected bleeding duodenal ulcer and a final diagnosis of duodenal ulcer at the time of discharge; and if so, does an agent have the power to bind the insurer by receiving such representation where there is a provision in the policy denying such power to the agent.

5. Does Rule 13(a) of the Federal Rules of Civil Procedure make a claim to the proceeds of a policy a compulsory counterclaim in a prior proceeding brought by the insurer to cancel the same policy.

REASONS FOR ALLOWANCE OF WRIT.

1. The Court of Appeals, in holding that testimony as to a conversation, not binding on Petitioner and admitted solely in connection with an alleged waiver, was legally sufficient evidence to establish the falsity of the Beth Israel Hospital record, has so far departed from the accepted and usual course of judicial proceedings as to call for the exercise of the power of supervision existing in this Honorable Court.

2. The Court of Appeals holds that the statute requires proof of an intention to deceive, and only bona fide answers to questions concerning hospitalization and consultation with or attendance by physicians even though the representations with respect thereto are shown to be both false and material to the acceptance of the risk, and further that there must be proof that the cause of the hospitalization was the cause of the death or existed when death occurred. This construction of the statute is contrary to its express provisions and to the construction placed upon similar statutes by other Federal courts. It is a question of sub-

stance involving the interpretation of a statute of the United States applicable to the District of Columbia which is of vital importance, not in this case alone, but to every contract of insurance in force in said District.

3. The Court of Appeals has decided important questions of law, relating to waiver based upon an admittedly incomplete disclosure of facts and also the validity of a contract provision limiting the power of an agent to bind the company by receiving any representation or information, and it has decided both questions contrary to applicable decisions of this Court.

4. The Court of Appeals has construed Rule 13(a) of the Federal Rules of Civil Procedure contrary to the intent of the rule and contrary to all other decisions of the Federal courts thereon.

Wherefore, your Petitioner respectfully prays that a writ of certiorari issue out of and under the seal of this Honorable Court to review the judgment entered by the United States Court of Appeals for the District of Columbia in this case on January 25, 1943.

The Prudential Insurance Company of America,

By

BENJAMIN S. MINOR,
ARTHUR P. DRURY,
JOHN E. POWELL,
Counsel for Petitioner.

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BRIEF IN SUPPORT OF PETITION FOR CERTIORARI.

I.

THE OPINION OF THE COURT BELOW.

The District Court wrote no opinion. The opinion of the United States Court of Appeals for the District of Columbia has not yet been officially reported but is included in the record herein (R. 188-210).

II

JURISDICTION.

The grounds upon which the jurisdiction of this Court is invoked are stated in the foregoing petition (p. 6).

III.

STATEMENT OF THE CASE.

The case has been briefly stated in the foregoing petition, which is hereby referred to and adopted as a part of this brief.

IV.

SPECIFICATION OF ERRORS.

1. The Court of Appeals erred in holding that there was an issue between the parties as to whether the Beth Isreal Hospital record was genuine or fictitious and that there was legally sufficient evidence to establish that it was fictitious.

2. The Court of Appeals erred in holding that under the statute it was necessary for petitioner to show the concealment of the Beth Israel Hospital record was intentional on the part of insured.

3. The Court of Appeals erred in holding that all the statute requires of an applicant for insurance is bona fide answers to inquiries concerning sojourns in hospitals and consultation with or attendance by physicians.

4. The Court of Appeals erred in holding that under the statute it was necessary for the insurer to show that the insured had the disease for which he was hospitalized and that it was the cause of death or existed when death occurred before it can avoid a policy because of misstatements in the application.

5. The Court of Appeals erred in holding that there was sufficient disclosure concerning the hospital record to establish waiver as a matter of law.

6. The Court of Appeals erred in holding that an agent of the insurer could receive representations and information in this case so as to bind the insurer contrary to a provision in the policy.

7. The Court of Appeals erred in holding that the claims to the proceeds of the policy were not compulsory counterclaims under the Federal Rules of Civil Procedure.

8. The Court of Appeals erred in holding that Petitioner was not entitled to a directed verdict in the trial court.

V.

SUMMARY OF ARGUMENT.

Jane Saxe was permitted to testify concerning a conversation with her husband, out of the presence of Petitioner, in which he told her that he had been in Beth Israel Hospital in Boston, not because he was ill but because he had too much to drink and that Dr. Fine agreed to falsify the record to make it look like he was sick. This testimony was admitted by the trial court to let the jury understand the background of an alleged waiver by Petitioner but it is taken by the Court of Appeals as evidence sufficient to establish the actual falsity of the hospital record. This results in Petitioner being dealt with unfairly and in denying to it the opportunity of producing testimony from Dr. Fine, and others, to show that the records of the hospital were true, and which it would have done had this testimony been admitted for this purpose at the trial.

The court also misconstrues a statute so as to require the insurer to prove the mental process of an applicant when he does not disclose hospitalization and treatment by doctors, and also to show that the cause of the hospitalization was the cause of death, or existed at the time of death, when all the statute actually requires is proof that the false statement was made either with intent to deceive or that it materially affected either the acceptance of the risk or the hazard assumed.

Furthermore, the ruling of the court that a representation to the insurer that the insured had been hospitalized because of a "social lapse" resulting from too much liquor is sufficient to support a waiver, as a matter of law, of the fact that the hospital record actually showed hospitalization for a duodenal ulcer, is contrary to the decisions of this Court that there must be a full disclosure in order to support a waiver.

The ruling of the court that a policy provision restricting the right of an agent to receive representations and information is ineffectual is also contrary to previous decisions of this Court.

In holding that a claim to the proceeds of a policy is not a compulsory counterclaim in a prior suit instituted for the purpose of cancelling the same policy, the court has misconstrued Rule 13(a) of the Federal Rules of Civil Procedure and construed the rule contrary to other Federal decisions.

ARGUMENT.

A.

Testimony Admitted By the Trial Court For One Purpose Cannot Be Used By An Appellate Court As Legally Sufficient Evidence For Another Purpose.

After devoting 8 pages to some of the facts the Appellate Court reaches the conclusion that

> "* * * the evidence is not only squarely in conflict, but substantially so, as to whether the Beth Israel hospitalization was genuine or fictitious. This affects nearly every issue in the case." (R. 195.)

There was no such issue before the case got to the Court of Appeals. The pre-trial order shows that the issues were materiality of the misrepresentation and waiver (R. 24) and the charge of the trial justice refers only to these issues (R. 109, 141 et seq). Dr. Fine, who was personally cross-examined by counsel, was asked nothing concerning the

supposed truth or falsity of the hospital record (R. 50). Yet he was the one who was supposed to have seen that the record was falsified (R. 104).

There was no legally sufficient evidence to establish the fictitious character of the Beth Israel Hospital records. The claimants admitted that the insured had spent from January 16, to January 30, 1934, in Beth Israel Hospital and had been treated therein by Dr. Fine (R. 22, 23), but neither offered any testimony as to the reason for the stay in the hospital and the treatment by Dr. Fine. The only evidence in the entire record with respect to this phase of the case is found in the testimony of Dr. Fine (R. 44) and in the hospital record (R. 155-183).

Jane Saxe, the wife, was permitted to testify to a conversation which she had with her husband when he went into a hospital for his last illness, in which he said that he had too much to drink on one occasion when he was building a house for Dr. Fine and went to the hospital (R. 101), that he wasn't actually ill but did not want to break his class record at Columbia University, so Dr. Fine agreed to fix up something in the hospital record so it would appear that he was ill (R. 104). This conversation, allegedly repeated to Brine, the local superintendent of the insurance company, was admitted by the trial court solely for the purpose of explaining to the jury the background of the alleged waiver (R. 82, 83, 85, 99, 101, 103, 109, 122, 127, 128), and none of it was admitted as binding on the insurance company (R. 101, 127). Brine denied that he was given this information with respect to Beth Israel Hospital (R. 113-117).

Nevertheless, the Court of Appeals has taken this testimony as the basis for its decision that

> "* * * this was not a genuine hospitalization, but was really a fictitious one for two purposes, to cover up an alleged 'social lapse' of the insured caused by overdrinking at a wedding party and thereby explain or

excuse his absence from his classes, and at the same time to complete the work he was doing as an architect for Dr. Fine on a house he was then building in Boston." (R. 192.)

That this testimony was considered by the Court of Appeals as creating an issue on, and legally sufficient to establish the fictitiousness of, the hospital record is shown by many other statements in the opinion:

"The medical evidence sustaining appellee's version of the Boston incident * * *". (R. 194.)

"He (Dr. Fine) was interested, in the sense that appellee's version of the Beth Israel episode, if true, called in question his professional ethics." (R. 194.)

"* * * appellee's version of the nature and purpose of the insured's admission and stay at Beth Israel takes on a verity it would not have if the hospital records and the medical testimony more strongly supported the insurer's version. Taking account of all the evidence in her behalf, we cannot regard it as inherently incredible, and for that reason improper for submission to the jury." (R. 194.)

"On the other (side) is a theory at most of recuperation from overindulgence in alcohol, without other than temporary if perhaps somewhat abnormal effects; or, of even less importance for insurance, of purely fictitious hospitalization for the sole purpose of supplying an apparently genuine, but actually false medical record of illneses * * *". (R. 194.)

"* * * on the evidence presented the falsity of all the answers was a question of fact and the jury has resolved this issue in each instance, on legally sufficient evidence, against it. This would be on the broad basis that the verdict has determined, in accordance with appellee's contention and the evidence supporting it, that the entire matter, including the records, of the Beth Israel hospitalization was fictitious, not genuine; * * *". (R. 197.)

"* * * if the jury believed that the Beth Israel hospitalization was wholly fictitious, including the hospital

records, it could find these answers were not false in fact.

* * * * *

These statements are not necessarily inconsistent, if it is believed he went to Beth Israel, as he said, not because he was really ill, but to cover up his 'social lapse'.

* * * * *

These things * * * made a substantial case for the jury that the misstatements were not made with intent to deceive, as against the evidence for the insurer * * *". (R. 200.)

"It assumes the insured, had he mentioned Beth Israel, would have done no more, that is, would not have disclosed the 'drinking episode' version of the incident.

* * * * *

* * * Prudential assumes * * * that the hospitalization was genuine, the records were genuine and correct. * * * These assumptions, so far as they have not been proved false, are highly speculative * * *". (R. 201.)

"The difficulty with this now is that the jury has found the Beth Israel episode was just what the insured said it was." (R. 202.)

The result of the decision of the Court of Appeals is that Petitioner is deprived of the right to meet the issue of alleged falsity of the hospital record. If that issue had been presented at the trial or if the testimony had been admitted on the frank issue of falsity of the record, it could have been met by testimony from Dr. Fine, the other doctors and nurses who participated in making the record, and from other sources.

For the Court of Appeals to take this hearsay testimony, admitted for a limited purpose and on an avowed issue of waiver, and hold it to be legally sufficient evidence to sustain a concealed issue of genuineness of the hospital record is such a distinct and harmful departure from the usual course of judicial procedure as to call for the supervisory power of this Court.

"A trial becomes unfair if testimony thus accepted may be used in an appellate court as though admitted for a different purpose, unavowed and unsuspected."

Shepard v. *United States,* 290 U. S. 96, 103.

B.

The Decision of the Court of Appeals Misconstrues the Statute.

The statute, which is set forth verbatim in the petition (p. 7) provides that recovery under a policy shall not be denied because of the falsity of a statement in the application unless it be proved that the statement was made (1) with intent to deceive *or* (2) unless it materially affected (a) the acceptance of the risk *or* (b) the hazard assumed by the company.

The trial court refused to receive testimony as to what Petitioner would have done had the hospital record been disclosed (R. 53) but it was proved as a general practice of insurance companies that if a history of hospitalization had been disclosed in the application the hospital records would have been examined, and if there was a diagnosis, or even a suspected diagnosis, of duodenal ulcer within three or five years the application would have been rejected without further inquiry (R. 69).

The Court of Appeals holds that "all the statute requires is that answers be made bona fide" (R. 201) and while "there were therefore misstatements of fact" and the insured "must have known he had been at Beth Israel Hospital" (R. 200) there was no showing that the insured "knowingly or intentionally spoke falsely" and therefore "the statements were not false, as a matter of law, except merely in the sense of being contrary to fact" (R. 201).

The Court does not recognize a difference between a question as to whether the applicant is afflicted with certain diseases, as to which good faith answers are all that can be required (*Moulor* v. *American Life Insurance Co.,* 111 U. S. 335) and a question whether the applicant has con-

sulted a physician or been in a hospital, matters of fact which are known to him and in which there is no room for opinion (*New York Life* v. *McCarthy* (C. C. A. 5th) 22 F. (2d) 241, *New York Life* v. *Hunter* (C. C. A. 8th) 32 F. (2d) 173, *Prudential Insurance Co.* v. *Loewenstein* (C. C. A. 4th) 76 F. (2d) 479).

There never can be a showing of the mental processes of an insured and for this reason the Federal courts have unanimously held that concealment of matters which must be known, such as sojourns in hospitals and medical attendance, are of themselves sufficient to establish the necessary intent. Among many such cases are: *Mutual Life* v. *Hilton-Green,* 241 U. S. 613, *Kavakos* v. *Equitable Life,* 66 App. D. C. 380, 88 F. (2d) 762; *Kaplan* v. *Manhattan Life,* 71 App. D. C. 250, 109 F. (2d) 463; *Columbia National Ins. Co.* v. *Rodgers,* (C. C. A. 10th) 93 F. (2d) 740; *Mutual Life* v. *Hurni Packing Co.,* (C. C. A. 8th) 260 Fed. 641; *Aetna Life Ins. Co.* v. *Perron,* (C. C. A. 7th) 69 F. (2d) 401; *Lawrence* v. *Connecticut Mutual Life,* (C. C. A. 6th) 91 F. (2d) 381; *Home Life Ins. Co.* v. *Madere,* (C. C. A. 5th) 101 F. (2d) 292; *Prudential Insurance Co.* v. *Loewenstein,* (C. C. A. 4th) 76 F. (2d) 479; *Raives* v. *Raives,* (C. C. A. 2d) 54 F. (2d) 267.

The Court of Appeals' construction of the statute is contrary to the construction placed upon similar statutes by other Federal courts, which have held that facts such as are presented in this case are sufficient under the statute to bar the right of recovery under the policy (*New York Life* v. *McCarthy* (C. C. A. 5th) 22 F. (2d) 241, *New York Life* v. *Simons* (C. C. A. 1st) 60 F. (2d) 30, *Fountain & Herrington* v. *Mutual Life,* (C. C. A. 4th) 55 F. (2d) 120, *New York Life* v. *Drooker* (D. C. Mass.) 53 F. (2d) 859, *Palmquist* v. *Standard Insurance Co.* (D. C. Cal.) 3 F. Supp. 356, *Equitable Life* v. *Carver* (D. C. Wash.) 17 F. Supp. 23).

Even where the statute requires that the misstatement in the application be shown to be willfully false and fraudulent, as well as material, the courts have held that there

could be no recovery in a case such as this (*New York Life* v. *Wertheimer* (D. C. Ohio) 272 F. 730, *New York Life* v. *Goerlich* (C. C. A. 6th) 11 F. (2d) 838, *Lyttle* v. *Pacific Mutual Life* (C. C. A. 6th) 72 F. (2d) 140; and the same is true where the statute requires that the misrepresentation contribute to the loss (*Hesselberg* v. *Aetna Life* (C. C. A. 8th) 75 F. (2d) 490, *Columbia National Life* v. *Rodgers* (C. C. A. 10th) 93 F. (2d) 740).

As this statute is construed by the Court of Appeals, no effect is given to the provision thereof which bars recovery if a false statement materially affects the acceptance of the risk. If effect is given to that provision, then the uncontradicted evidence in the case is that the application would have been declined had the hospital record been disclosed, and the concealment thereof being a material misrepresentation as a matter of law, the trial court should have directed a verdict for the company, and the Court of Appeals should have held there was no liability on the insurer.

The dissenting opinion recognizes the true situation and holds:

> "Case No. 7824 should, in my opinion, be reversed for failure of the trial court to direct a verdict for the appellant: In view of the insured's Beth Israel Hospital experience, and his medical history as disclosed in the Hospital records, I think the insured's negative answers to question 6d, 7a, 9a and 10a and his affirmative answer to question 10b of the insurance application constituted misstatements which all reasonable jurymen must have found materially affected the acceptance of the risk; * * *" (R. 210.)

C.

The Effect of the Opinion of the Court of Appeals is That, Under the Statute, it is Necessary to Establish that the Insured Had Disease For Which He Was in the Hospital and that it was the Cause of Death or Existed When Death Occurred.

The principal contention of Petitioner was that the insured, in concealing his hospital record had committed a fraud and misrepresented a matter which was material to the acceptance of the risk. It is not necessary, under the statute, to do more.

The Court of Appeals now holds that:

> "A misstatement to be material to the hazard assumed must be shown in some way to have affected it or contributed to the loss, and in a substantial manner." (R. 201)

In order to bring this case within that ruling the Court of Appeals misstates Petitioner's contention to be that there was a real hospitalization with a diagnosis of duodenal ulcer and that "it was the cause of death or existed when death occurred" (R. 195) but that "the insurer did not prove, to the jury's satisfaction, that the insured ever had duodenal ulcer" (R. 198).

There is no requirement in the statute that the misstatement contribute to the loss in any way. That is the statute law of the State of Missouri (Sec. 5843 R. S., 1939). Apparently the Court of Appeals was trying to read the law of Missouri into the statute law of the District of Columbia, as shown by the reference made by it to Missouri cases (R. 196, 197), none of which were cited to it in any brief. But even under the Missouri statute the Federal courts hold that matters such as are involved here are material as a matter of law and the policy is voidable even though the untrue answer was made in good faith, *Hesselberg* v. *Aetna Life Ins. Co.*, (C. C. A. 8th) 75 F. (2d) 490.

If such is to be the law of the District of Columbia, it should be enacted by the Congress, not by the Court of Appeals.

D.

The Court of Appeals' Opinion is Contrary to the Decisions of This Court with Respect to Waiver and the Contract Provision Limiting the Authority of An Agent.

The opinion holds that the statement made by Jane Saxe to a representative of the insurer, that the insured had been in the hospital for a 'social lapse' but was not ill, was sufficient to support a waiver, as a matter of law, of the fact that the hospital record actually showed he was in the hospital for two weeks with a suspected diagnosis of bleeding duodenal ulcer and a final diagnosis of duodenal ulcer (R. 203).

The dissenting opinion properly holds that:

> "* * * the alleged waiver of appellant's right to avoid the policy because of misstatements in the application was as a matter of law ineffective for the reason that undisputedly the material facts concerning insured's Beth Israel Hospital experience and medical history as shown by the Hospital records were not fully disclosed to the appellant at the time of the alleged waiver. Waiver is an intentional relinquishment of a right and therefore requires knowledge of the existence of the right or of the facts upon which the same depends." (R 210.)

In holding as it does, the majority opinion casts aside the legal principles established by this Court in the cases of *Bennecke* v. *Connecticut Mutual Life Ins. Co.*, 105 U. S. 355, and *Globe Life Insurance Co.* v. *Wolff*, 95 U. S. 326, on the sole ground that the fact sought to be waived in those cases was the death of the insured (R. 203). The principle of law established in these cases is still the law and has been followed not only by this Court but by other Federal courts.

The policy contained the following provision:

> "Modification, etc.— * * * No Agent has power * * * to waive any forfeiture, or to bind the Company by making any promise, or by making or receiving any representations or information." (R. 152.)

The Court of Appeals holds that this policy provision is ineffectual, and condemns it on the authority of one Mississippi case (R. 204) notwithstanding this Court has held such provisions valid and binding in many cases: *Prudential Life* v. *Moore,* 231 U. S. 543, *New York Life* v. *Fletcher,* 117 U. S. 519, *Northern Assurance Company* v. *Building Association,* 183 U. S. 308, *Penman* v. *Fire Insurance Co.,* 216 U. S. 311, *Lumber Underwriters* v. *Rife,* 237 U. S. 605, *Mutual Life* v. *Hilton-Green,* 241 U. S. 613, *Sun Insurance Co.* v. *Scott,* 284 U. S. 177.

E.

The Court of Appeals Misconstrues Rule 13(a), Federal Rules of Civil Procedure.

This rule is as follows:

> "Compulsory Counterclaims. A pleading shall state as a counterclaim any claim, not the subject of a pending action, which at the time of filing the pleading the pleader has against any opposing party, if it arises out of the transaction or occurrence that is the subject matter of the opposing party's claim * * *".

The Court of Appeals says that to apply the rule to this case forces a surrender of a trial by jury by the claimants to the fund (R. 208). It also says that the rule does not apply to this case because "at the time of the filing of the pleading, namely, the counterclaim, the claim it stated *was* 'the subject of a pending action', namely, appellee's suit" (R. 208). In other words, it holds the claimant having filed a separate suit before she filed her counterclaim, the rule does not apply to her when she comes to answer the prior

suit filed by the insurer. This ignores the fact that there was an even earlier suit involving the same transaction and filed by the insurer.

Such an interpretation does not carry out the intent of the Federal Rules of Civil Procedure and is contrary to the judgments of other Federal courts with respect to similar subject matter:

Union Central Life v. *Burger* (D. C. N. Y. 1939) 27 F. Supp. 554,
Judson v. *Buckley* (D. C. N. Y. 1940) 31 F. Supp. 246,
New England Mutual Life v. *Barnet* (D. C. Ala. 1941) 39 F. Supp. 761,
Pennsylvania Railroad Co. v. *Musante-Phillips* (D. C. Cal. 1941) 42 F. Supp. 340,
Williams v. *Robinson* (D. C. D. C. 1940) 1 F. R. D. 211,
Hancock Oil Co. v. *Universal Oil Products* (C. C. A. 9th 1940) 115 F. (2d) 45,
Beauknit Mills v. *Eday Fabric Sales Corp.* (C. C. A. 2d, 1942) 124 F. (2d) 563,
John R. Alley Co. v. *Federal National Bank,* (C C. A. 10th 1942) 124 F. (2d) 995,
Holtzoff, New Federal Rules, pp. 44, 110,
Federal Rules Institutes:
New York Proceedings, p. 275,
Washington Proceedings, p. 58,
Cleveland Proceedings, p. 247.

CONCLUSION.

The Court of Appeals seems to have entirely overlooked the fact that the insured, by falsely stating that he had never been in a hospital, deprived Petitioner of a very material part of the information which was necessary to enable it to determine whether or not it would enter into the proposed contract and wrongfully withheld from it the means of making an investigation to that end. To say, as the court does, that no harm resulted from the concealment, because had the insured disclosed the hospital record he would have disclosed also a version of it which the

claimants made no attempt to establish legally at the trial, ignores the fact that he thereby obtained a valuable contract which is now being enforced.

> "This is bad morality and bad law. No one may do evil that good may come. No man is justified in the utterance of a falsehood."
>
> *Jeffries* v. *Insurance Company,* 22 Wall. 47, 52.

For the Appellate Court to support the advantage so gained, by holding that testimony admitted for a limited purpose is sufficient and competent to establish a different issue, and by ignoring long established legal principles, is to assist in depriving Petitioner of the right to determine for itself whether it would accept the proffered risk in the light of the true facts.

The judgment should, therefore, be reviewed by this Court.

Respectfully submitted:

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(19)

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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1942.

No. 878.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, a corporation, *Petitioner*,

v.

JANE SAIS, *Respondent*.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI.

[redacted]

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1942.

No. 878.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, a corporation, *Petitioner*,

v.

JANE SAXE, *Respondent*.

BRIEF OF RESPONDENT JANE SAXE IN OPPOSITION TO PETITION FOR CERTIORARI.

I.

STATEMENT OF THE CASE.

The Petitioner's statement of the case is inaccurate, incomplete and misleading. The established facts are as follows:

The insured, Alexander T. Saxe, applied for a $10,000 life insurance policy with the Petitioner, Prudential Insurance Company of America, in November, 1936 (Tr. 52). The policy was issued in December, 1936 and the beneficiary named in it was the insured's wife, Respondent Jane

Saxe, (Tr. 53) whom insured had married a few months before (Tr. 51). She paid the premiums on the policy until her husband's death (Tr. 55). Toward the end of 1937, the insured became ill, went to the Garfield Hospital on December 29, 1937 and died on January 30, 1938 (Tr. 55). The cause of his death as determined by an autopsy performed at the Garfield Hospital was malignant hypertension of a duration of a year or less (Tr. 79-81). The Petitioner refused to pay the claim of the Respondent as beneficiary and she brought suit in the District Court of the United States for the District of Columbia for the proceeds of the policy. The procedural matters involved will be discussed later.

Petitioner contested the policy on the ground that the insured had made material misrepresentations in the application. The alleged misrepresentations centered in a record of hospitalization at the Beth Israel Hospital, Boston, Massachusetts, which the insured failed to disclose in the application. This hospitalization occurred in January, 1934, almost three years before the application for the policy was made. Petitioner claimed that insured represented that he had not had duodenal ulcer, abnormal blood pressure, dizziness—loss of consciousness and kidney disease and that these representations were both false and material. It relied primarily on the Beth Israel record for proof.

No evidence was offered nor was it seriously urged at the trial that the insured's failure to disclose this was intentional and, in fact, there was evidence that the insured had forgotten the incident (Tr. 363). There was no evidence that the insured knew or had been told what medical findings were made in the Beth Israel record.

The Respondent produced strong evidence to show that the insured was not a bona fide patient during this hos-

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Note. References are either to the transcript of the original record filed herein pursuant to stipulation of the parties (Tr. ——) or to the printed record herein (R. ——).

pitalization and that the health of the insured in the period between the hospitalization and the application was such that the hospitalization could not have been of any consequence. The lack of illness at Beth Israel was demonstrated from the hospital record itself which, while it offered a final diagnosis of duodenal ulcer (Tr. 791), also showed that the insured was entirely sympton free during his entire stay in the hospital (Tr. 814), that he was in no distress (Tr. 796) and that repeated physical examinations were essentially negative (Tr. 789-840). Dr. Pope, on behalf of Respondent, analyzed this record and stated that in his opinion the laboratory data, x-rays and general physical findings in the record proved that the insured did not have duodenal ulcer, nephritis or hypertension (Tr. 82-88). There was uncontradicted testimony by the insured's mother that during his stay in the Beth Israel Hospital he had had subcontractors working with him and conducted business from his hospital room during his entire stay (Tr. 128, 129). It was also established without contradiction that the insured played baseball in the Spring after the hospitalization (Tr. 131, 132). He came to Washington in the Fall of the same year and in the seasons of 1935 and 1936 he pitched an average of two games a week on Government baseball teams. He bowled on bowling teams during the Winters and he played football with the George Washington University football squad in the Fall (Tr. 309, 312, 313). Numerous witnesses testified that during this period he was an active vigorous man and appeared to be in good health (Tr. 305, 311, 303, 308, 299). Dr. Krause, the examining physician for the Petitioner, testified that at the time the insured was examined for the policy in November, 1936, he was in excellent health and that the urine analysis and blood pressure tests made by Dr. Krause during this examination showed no evidence of nephritis or hypertension. Dr. Krause classified him as an excellent risk (Tr. 320-324).

Respondent also showed that the petitioner had waived any right to void the policy on the ground of the Beth Israel hospitalization because it had accepted payment of three premiums during the month after knowledge of the facts had been communicated to its Washington superintendent. The evidence on this was set out in the opinion of the Court of Appeals (R. 192-194).

As to the procedural matters, Jane Saxe verified her complaint for the proceeds of the policy on October 3, 1938 and filed it on October 5, 1938. On the intervening day, October 4, 1938, the Petitioner filed an action against Respondent and Gertrude T. Saxe, mother of the insured, for cancellation of the policy on the ground of fraud. This was designated as Civil Action No. 178 and the action for the proceeds of the policy was designated as Civil Action No. 186.

The Petitioner moved to stay the suit on the policy on the ground that it should have been pleaded as a compulsory counter-claim in the action for cancellation. Mr. Justice Luhring denied this motion on November 10, 1938, counsel having argued that Respondent would be deprived of a jury trial on the fraud issue if she were required to proceed in the cancellation suit. The Petitioner then answered and pleaded by way of defense to the action on the policy, the matters alleged in its complaint for cancellation. Respondent then moved to stay the cancellation action which motion was denied without prejudice to renewal after an answer had been filed. An answer setting up the claim for the proceeds of the policy as a counter-claim was filed by Respondent and the motion to stay the cancellation suit was made again and denied.

At pretrial, Mr. Justice Laws suggested that the two cases be consolidated. The Petitioner again argued in effect that the Respondent's action should be stayed and that the issues which were identical in both suits should be tried by the court without a jury. Mr. Justice Laws pointed out to counsel that no order had been entered on the denial

by Mr. Justice Luhring of the original motion to stay the Respondent's action. Counsel for all parties then conferred with Mr. Justice Luhring in chambers on June 4, 1940 and the matter was fully discussed again after which Mr. Justice Luhring signed an order on June 5, 1940 denying nunc pro tunc the Petitioner's motion to stay which he had decided on November 10, 1938.

On June 6, 1940, Mr. Justice Laws signed a memorandum of pretrial proceedings consolidating the two cases for trial and stating (R. 25):

> " * * * it appearing the complete remedy of both parties is available in a law action, the suggestion or recommendation is made to the trial court that the plaintiffs in the law cause be permitted to open and close the proceedings."

The Petitioner then moved for a rehearing of the original motion to stay the Respondent's suit, Mr. Justice Luhring denied this on October 3, 1940. At the opening of the trial in the District Court the Petitioner moved to have the cancellation suit tried first. This motion was denied by the trial court which adopted the recommendation of the pretrial justice and tried the consolidated case with a jury.

The jury rendered a verdict in favor of the Respondent Jane Saxe on October 10, 1940, and the Petitioner appealed from the judgment entered on such verdict to the United States Court of Appeals for the District of Columbia which affirmed the judgment on January 25, 1943. The majority opinion of the Court of Appeals was written by Mr. Justice Rutledge and Mr. Justice Stephens dissented. The Petitioner now seeks a writ of certiorari from this Honorable Court.

ARGUMENT.

A fundamental misconception of the issues pervades Petitioner's argument. Petitioner's major argument is predicated on the erroneous assumption that the insured was actually hospitalized in the Beth Israel Hospital for duodenal ulcer and other ailments, whereas the substantial proof and verdict demonstrated that this was not the case. A glance at (R. 23 (4) and (5)) will show that the Respondent denied that all of the statements in the Beth Israel record were true and denied that the insured was a bona fide patient. The truth of the Beth Israel record and the question of whether the insured was actually ill while there have been major issues throughout this case and have been found in favor of the Respondent on ample evidence.

It should be borne in mind that in order to defeat the policy the Petitioner was bound to prove either that the insured made false representations with intent to deceive or that such representations were material. No intent to deceive was proven.

Petitioner proved that the insured was "in" a hospital nearly three years before the application. It did not prove that the insured was ill while there nor did it offer any real evidence of other illnesses. Against this the Respondent produced convincing medical testimony that the insured was not really ill at the hospital, uncontradicted testimony that insured conducted his business from the hospital room during his stay and numerous witnesses who proved the good health and unusual athletic activity of the insured during the three years between the hospitalization and the application. The Petitioner's own medical examiner classed the insured as an excellent risk after a thorough examination. Respondent also showed that the insured died over 14 months from the date of the application of a disease which existed for a year or less. On this state of evidence, the matter was clearly for the jury and the Court of Ap-

peals was correct in sustaining the judgment in favor of the Respondent on the jury's finding.

Wharton v. *Aetna Life Ins. Co.*, 48 F. (2nd) 37 (C. C. A. 8, 1931) cert. denied 284 U. S. 621.
N. Y. Life Ins. Co. v. *Cumins*, 24 F. (2nd) 1 (C. C. A. 3rd, 1938).
Kaplan v. *Manhattan Life Ins. Co.*, 71 App. D. C. 250 109 F. (2nd) 463 (Ct. App. D. C. 1939).
Jones v. *U. S.*, 112 F. (2nd) 282 (C. C. A. 8th, 1940).

This phase of the case was aptly summarized by the trial court who remarked to Petitioner's counsel out of the presence of the jury, "I don't believe that they [Petitioner] would have paid the slightest attention to that sickness in the hospital". (Tr. 631.) The other phases of the case, waiver and procedure, will be discussed in the consideration of Petitioner's brief following.

AS TO POINT A OF PETITIONER'S BRIEF.

Petitioner argues in Point A of its brief that the Court of Appeals injected a new issue into the case not considered at the trial and reached its decision on that issue on evidence admitted for a limited purpose. This argument is based on a misinterpretation of the court's language and the basic misconception of the issues explained before. It also places a false emphasis on the court's use of the word "fictitious" to characterize the Beth Israel incident.

Petitioner maintains that the truth of the Beth Israel record was not in issue at the trial and that, therefore, it was deprived of the right to produce evidence to meet this issue. It is perfectly obvious from the record that Petitioner knew long before the trial that the Respondent had denied the truth of the Beth Israel record (R. 23 (4)) and denied that the insured was a bona fide patient (R. 23 (5)). Petitioner had ample opportunity to prepare for and meet this issue at the trial if it could. The Court of Appeals properly recognized this issue.

In *Shepard* v. *U. S.*, 290 U. S. 96, on which Petitioner relies, a Dr. Shepard was on trial for the murder of his wife. The wife's statement to the effect that her husband had poisoned her was admitted by the trial court as a dying declaration although she did not die until some time later. The Circuit Court of Appeals ruled that while the statement was inadmissable as a dying declaration it could have been admitted for the limited purpose of showing her state of mind in rebuttal of other declarations which indicated a suicidal intent. This court held that the appellate court could not take inadmissable evidence generally introduced and sustain its admission on a limited ground because the trial court would have had to explain the limitation to the jury to define the bounds within which the statement could be used as evidence. It further held that the balance of interest was clearly against admitting the evidence on any theory.

In the present case, the Court of Appeals has not taken any such action. The court gave a clear explanation of the issue on page 4 of the opinion (R. 191) which was:

> "There is no dispute that the insured was 'in' the hospital for the two weeks. But there is a square clash on the reason and purpose of his being there and the consequences for the insurer's liability. The evidence, and the conflict, are crucial both for the issues concerning the alleged misrepresentations and their effects and also for the claimed waiver."

The case did not go to the jury solely on the evidence referred to by the Petitioner but on the substantial evidence set forth in the opinion in great detail. On this score the court said (R. 195):

> "Taking account of all the evidence in her behalf, we cannot regard it as inherently incredible, and for that reason improper for submission to the jury."

The Court of Appeals committed no error and no question is presented for review of the decision on this point.

AS TO POINT B OF PETITIONER'S BRIEF.

The D. C. statute (Act of Congress of June 19, 1934, 48 Stat. 1133 c. 672, par. 15, ch. II) (District of Columbia Code (1940) sec. 35-414) provides:

> "The falsity of a statement in the application for any policy of insurance shall not bar the right to recovery thereunder unless such false statement was made with intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the company."

Petitioner claims that in interpreting this statute, the Court of Appeals gave no effect to the provision thereof which bars recovery if a false statement materially effects the acceptance of the risk. The Court of Appeals made no such ruling as a reading of the opinion will disclose. It did hold that there was a substantial evidentiary conflict on the falsity and materiality of the insured's representations and that the conflict was resolved by the jury in favor of the Respondent on sufficient evidence.

With a conflict in evidence on the material facts, the case was properly submitted to the jury under the cases cited on page 7 supra.

There is a sharp distinction between the cases in which there is no conflict in the material facts and the ones in which there is a conflict. The Petitioner relies on the former line of cases but they are not applicable to the case at bar because of the substantial conflict in evidence herein. In practically all of the cases cited by the Petitioner, the insured concealed a very material matter. For example, in *Mutual Life* v. *Hilton-Green*, the insured concealed a previous unsuccessful application for insurance as well as prior consultations with doctors; in *Kavakos* v. *Equitable Life*, the insured concealed 80 consultations with doctors over a short period prior to the application; in *Columbia National Insurance Co.* v. *Rogers*, the insured concealed a rejected application for insurance within 10 months prior to the application in question; in *Mutual Life* v. *Hurni*

Packing Co., the insured concealed numerous consultations with doctors, three months rest at a health resort and a course of serum injections; in *Aetna Life Insurance Co.* v. *Perron*, the insured concealed a complicated glandular ailment and numerous consultations with physicians and hospitalization for diagnosis; in *Lawrence* v. *Connecticut Mutual Life*, the insured concealed numerous consultations with physicians, sojourn in a hospital, operation on his neck, deep therapy and statements of his doctor and surgeon that he had sarcoma; in *Home Life Insurance* v. *Madere*, the insured concealed an operation for an infected cyst and other illnesses; in *New York Life* v. *McCarthy*, the insured concealed the fact that he had consulted doctors frequently in the three years prior to the application for a growth near his heart; in *Fountain and Harrington* v. *Mutual Life*, the insured concealed appendicitis pains for which an operation was required a couple of months after the application; in *New York Life* v. *Drooker*, the insured concealed consultations with doctor, periodic urine analyses over 18 months and a restricted diet; in *Equitable Life* v. *Carver*, the insured concealed sleeping sickness which had impaired his right side and rejections of two prior applications for insurance.

The facts in the present case are clearly under the rule of *Wharton* v. *Aetna Life Insurance Co. supra*, page 7. There the court said (p. 43):

> "The jury might, under the evidence, have believed that the insured, in good faith believed that except for the appendicitis all other ailments for which he had consulted a physician were of a trivial character. To void this policy on the ground of false representation, the answer must not only have been untrue but it must have been with reference to a material matter and must have been knowingly false. When it is doubtful whether the misrepresentation was material or not, the question of materiality must be submitted to the jury."

The Wharton case was before this court on a petition for certiorari which was denied in 284 U. S. 621. In that pro-

ceeding, the Respondent's brief set out a very thorough analysis of the federal cases on the point and we respectfully direct the court's attention to that discussion (*Wharton* v. *Aetna Life Insurance Co.*, Docket No. 103, October Term 1931, Respondent's Brief pp. 22 et seq.)

Under the Wharton case, no question is presented for review by this court.

AS TO POINT C OF PETITIONER'S BRIEF.

Petitioner contends that under the opinion it is necessary to establish that the insured had the disease for which he was hospitalized and that it was the cause of death or existed when death occurred to defeat the policy. This contention goes far beyond the opinion and fails to comprehend the court's actual decision.

The statute requires misrepresentations to be either made with intent to deceive or material to the "acceptance of the risk" or "hazard assumed" by the company. The court found that the insured's statements were not made with intent to deceive and that, due to the conflict in evidence on materiality, the question of materiality was for the jury and found in favor of the Respondent. It then discussed the alternate "hazard assumed" phrase of the statute. In passing, the court stated (R. 201) that a misstatement to be material to the "hazard assumed" must be shown in some way to have affected it or contributed to the loss and in a substantial manner. This is a perfectly correct statement of law but the petitioner's argument fails to recognize the distinction between "hazard assumed" and "acceptance of the risk" and the separate treatment of the two phrases by the Court of Appeals.

Hesselberg v. *Aetna Life Insurance Co.* cited by the Petitioner is not applicable because of the materiality of the concealment. There the insured represented that he had not consulted a doctor or suffered any injuries. The undisputed facts were that 8 days before the representations, the insured had been in an automobile accident, and con-

sulted a doctor for his injuries and was starting a law suit in which he subsequently recovered $25,000 for the injuries.

AS TO POINT D OF PETITIONER'S BRIEF.

Petitioner complains that the court's decision on waiver was contrary to the decisions of this court. Here again this argument is based on the unestablished premise that the insured had duodenal ulcer and other ailments when he was in the Beth Israel hospital. Actually, the insured told the Petitioner all he knew concerning the hospitalization. No more would have been required of him in answering the application. A full month before the insured died, the information was communicated to the Washington Superintendent of the Petitioner, a man who admittedly had authority to solicit risks and accept payments of premiums and who was held out by his license from the Superintendent of Insurance of the District of Columbia as a general agent of the Petitioner. The Petitioner accepted three premiums after this information had been communicated to its local superintendent and took no action until after the insured died, a month later. It should be noted that the Court of Appeals rested its decision on a narrow ground. The actual basis was (R. 205):

> "In this case Brine was not without authority to receive information on the company's behalf. He was authorized to forward complaints and controversies concerning matters affecting policies to the home office. It was his duty to do this. When he failed, it was a breach of his duty to the company, and at the same time of its duty to the insured and to the beneficiary. Under the circumstances, in which the knowledge was communicated, the insurer owed them the obligation to act, to do so promptly, and in such a manner as not to lull them into false security, so that the loss would fall and foreclose any opportunity to secure further action to establish, preserve or settle their rights. If more was needed than was done, the insurer should have informed the insured or his representative what it was. It cannot now shift to appellee's shoulders the burden

of Brine's breach of duty to itself, or of its own duty to the insured. Consequently when Brine received the knowledge and failed to communicate it promptly to his principal, that is, the home office, it became charged with notice of the existence of the grounds for forfeiture. When, in addition, it received the premiums and allowed the matter to rest for nearly a month, and until the loss had fallen, without returning them or doing anything further about the matter, the waiver was effectually completed. We have purposely put the matter thus narrowly, because on these facts it is not necessary to decide whether Brine's receipt of the information and the premiums, without more, would have been sufficient as a waiver."

This holding is perfectly in accord with principles laid down by this court. In *Globe Mutual Life Insurance Co.* v. *Wolff*, 95 U. S. 326, 24L Ed. 387, this Court said, (p. 332)

> "It is true that where an agent is charged with the collection of premiums on policies it will be presumed that he informs the Company of any circumstances coming to his knowledge affecting its liability; and, if subsequently the premiums are received by the Company without objection, any forfeiture incurred will be presumed to be waived."

And in *Phoenix Mutual Life Insurance Company* v. *Raddin*, 120 U. S. 183, this Court said, (p. 196)

> "It follows that the only question upon the instructions of the court to the jury which is open to the defendant on this bill of exceptions is whether if insurers accept payment of a premium after they know that there has been a breach of a condition of the policy, their acceptance of the premium is a waiver of the right to avoid the policy for that breach. Upon principle and authority there can be no doubt that it is. To hold otherwise would be to maintain that the contract of insurance requires good faith of the assured only, and not of the insurers, and to permit insurers, knowing all the facts, to continue to receive new benefits from the contract while they decline to bear its burdens."

See also *Bowles* v. *Mutual Benefit Health & Accident Association*, 99 F. (2d) 44, 119 A. L. R. 756 (C. C. A. 4th, 1938).

No question is presented for review on this point.

AS TO POINT E OF PETITIONER'S BRIEF.

The procedural steps herein are set forth in the Statement of the Case, supra, pp. 4, 5. It should be borne in mind that this action was instituted two weeks after the adoption of the new rules. Respondent throughout the entire proceedings insisted on her right to a jury trial under *Phoenix Mutual Life Insurance Company* v. *Bailey*, 80 U. S. (13 Wall) 616 and *Adamos* v. *New York Life Insurance Company*, 293 U. S. 386.

Petitioner has not stated the true ratio decidendi of the Court of Appeals on this point. On page 19 of the opinion, the court said (R. 206):

> "It remains to consider the alleged procedural errors. There was no error in consolidating the causes for trial or refusing to try the so-called equitable issues separately and before proceeding with the trial at law. The insurer's suit to cancel the policy was filed the day before Jane Saxe instituted her suit to recover on the policy, in which Gertrude Saxe intervened. The grounds asserted for cancellation were the same as those relied upon for defense in the suit to recover on the policy. The parties were the same. It was clearly proper therefore for the court to consolidate the causes and submit the entire matter to jury trial."

The court then discussed the various contentions urged by the parties, including the Petitioner's arguments on Rule 13a, and concluded (R 208—209):

> "Finally, Rule 42 confers on the District Court broad discretionary powers for consolidation of actions 'involving a common question of law or fact.' Rule 13 (a) should be construed in harmony with it. We need not decide, therefore, whether appellee had a right to jury trial, in these circumstances, or whether it would

have been an abuse of discretion to deny it. The court's discretion was exercised in her favor, and there clearly was no abuse in so exercising it. This applies both to the consolidation of the causes and to the denial of the motions, after consolidation, for the separate and prior trial of the so-called equitable issues."

There are two other Circuit Court cases of interest on this point. In *Barnett* v. *New England Mutual Life Insurance,* 123 F (2d) 712, (C.C.A. 5th, 1941), which reversed the lower court decision relied on by Petitioner, the insured died within the contestable period. The insurer filed an action for cancellation in January, 1939. In September, 1939, the beneficiary sued on the policies. The insurer obtained a stay on this action pending disposition of its suit for cancellation. The beneficiary answered the cancellation suit and counterclaimed for the proceeds of the policy. The cause was tried before a jury but at the close of the evidence the court dismissed the jury, treated the case as one of equitable cognizance, and entered a decree of cancellation. The Circuit Court of Appeals held that it was error to treat the action as of a purely equitable nature, that the fraud defense was fully available to the insurer as a defense to any action on the policies and that there was no occasion for granting equitable relief.

And in *Federal Life Insurance Co.* v. *Ettman,* 120 F (2d) 837, (C.C.A. 8th, 1941), the insurer brought suit for cancellation of a disability policy. Eleven days later the insured brought suit for disability benefits and moved to dismiss the insurer's suit for cancellation. The motion was granted, the insurer appealed and the Circuit Court of Appeals sustained the dismissal of the cancellation suit on the ground that the insurer's remedy was adequate in the law action.

The holding of the Court of Appeals herein is in harmony with these decisions under the Federal Rules of Civil Procedure and with the decisions of this court in the Bailey and Adamos cases (supra p. 14). No question is presented for review.

CONCLUSION.

The Petitioner, in order to defeat recovery on the policy, was required to prove that the insured made false statements either with intent to deceive or that materially affected the acceptance of the risk or hazard assumed by the Petitioner. It conspicuously failed to do this. On the other hand, the Respondent showed by convincing medical testimony that the insured was not ill at the Beth Israel Hospital; that he enjoyed excellent health and demonstrated unusual athletic activity for nearly three years before the policy was issued; and that the facts of the hospitalization were disclosed to the insurer's local superintendent and thereafter the insurer accepted payment of three premiums. The jury's verdict in favor of Respondent and the judgment thereon were found on sufficient evidence. No error was made in permitting a jury trial of the issues. The Court of Appeals has followed the decisions of this court applicable to the facts, its decision is entirely correct and we respectfully submit that no question is presented for review. The petition for a writ of certiorari should be denied.

Respectfully submitted:

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